CHARLESTON ONCOLOGY
COMPASSIONATE CARE FOR CANCER AND BLOOD DISORDERS
A Department of Bon Secours St. Francis Hospital

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name _____ **Date of Birth** _____

Address _____

City, State, Zip _____

Please list the names of any person authorized to receive medical information concerning the patient:

_____ _____
_____ _____
_____ _____

Initial each method you authorize the above person(s) to receive patient information:

_____ Voicemail
_____ E-mail
_____ Phone conversation

Description of information to be released (Initial those that apply):

_____ Date and time of my next appointment and with whom
_____ Information results from any test or x-rays
_____ Other information as described:_____

This authorization shall be in force and in effect until revoked by the patient or representative signing the authorization.

RIGHTS OF THE PATIENT

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME BY SENDING A WRITTEN NOTIFICATION TO: ADMINISTRATOR, 2085 HENRY TECKLENBURG DRIVE 2ND FLOOR, CHARLESTON, SC 29414.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

I UNDERSTAND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE USED TO DISCLOSE AS DESCRIBED IN THIS DOCUMENT. I CAN DO THIS BY WRITTEN NOTIFICATION TO: ADMINISTRATOR, 2085 HENRY TECKLENBURG DRIVE 2ND FLOOR, CHARLESTON, SC 29414.

I UNDERSTAND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Date